THE KAISER-HCFA STATE SYMPOSIA SERIES

TRANSITIONING TO MEDICAID MANAGED CARE

CONSUMER PROTECTION: LESSONS LEARNED FROM STATES

Prepared
by
Robert L. Mollica
Trish Riley
Jane Horvath
Neva Kaye

December
1996

NATIONAL ACADEMY
for STATE HEALTH POLICY

Funded by The Henry J. Kaiser Family Foundation, Menlo Park, California
and the Health Care Financing Authority through a contract with Research Triangle Institute

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EXECUTIVE DIRECTOR
Trish Riley

MEMORANDUM

TO: Participants, Kaiser-HCFA Symposia Series

FROM: Trish Riley Trish

DATE: January

Thank you again for your participation in the October 23rd Kaiser-HCFA State Symposia Series on Transitioning to Medicaid Managed Care. Our discussion of consumer protection was a rich one which we hope we have adequately captured in this report. We also appreciate your review and edit of the drafts of this document.

We apologize that it has taken us this long to get a final document to you, but we wanted to be certain that it adequately represents the discussion. We look forward to additional symposia and encourage you to let us know what topics would be most valuable for future discussions and papers like this one.

Thank you very much for all your help. We hope you find this document well represents the concerns raised at the October Symposium.

Thank you.

TR:se

Enclosure

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Executive Summary

As states transition their Medicaid programs into a sometimes chaotic and always fast moving managed care marketplace, careful consideration is required to protect Medicaid beneficiaries and assure them access to quality care. Based upon a day-long discussion with state officials, this paper summarizes how states are developing those consumer protections through enrollment and disenrollment systems, strategies to involve consumers, outreach and education activities, and complaint and grievance procedures. It was the intention of this work to focus only on those activities—and not the broader responsibilities of states in monitoring managed care—in order to elucidate lessons learned. This paper, then, is a brief synthesis of selected state practices and a practical checklist of lessons learned. We hope the paper will help other states further advance innovative approaches to reaching and enrolling Medicaid beneficiaries in managed care which best serves their needs. Some of the highlights include:

- The process of enrolling and educating beneficiaries about managed care is critical to beneficiary satisfaction with and appropriate use of the system.

- State enrollment mechanisms vary significantly. Ten states use state employees, 24 states contract with independent brokers and several have developed significant roles for managed care plans.

- If state employees are used to enroll Medicaid beneficiaries in managed care, participants recommended separating enrollment from eligibility and carefully training and supervising workers by Medicaid staff.

- The functions, methods of reimbursement and performance criteria developed by states for independent brokers vary among states. Some states have brokers conduct enrollment only while brokers in other states are also responsible for tracking disenrollment, and still others assign brokers responsibility for handling complaints and grievances.

- Use of auto assignment and disenrollment rates to monitor and/or reimburse independent brokers remains controversial. Since states all define auto assignment and disenrollment differently, no acceptable norm for auto assignment and disenrollment was identified.

- Independent brokers are paid either a flat rate for service or a rate per beneficiary enrolled. At this time, no consensus exists about a preferred method to reimburse brokers. States using a rate per beneficiary need to develop practices that monitor incentives to enroll beneficiaries inappropriately. If brokers also handle complaints and grievances, other incentives are created that warrant monitoring.

- States have attempted to overcome incentives for inappropriate enrollment by carefully crafting contracts and expectations, withholding payments which are paid only if the broker meets standards such as call waiting time, phone rates and other indicators.

- States have facilitated the involvement of consumer groups and advocates in ways that have increased the effectiveness of their programs.

- Participants felt that face to face meetings with beneficiaries were more effective than phone and mail encounters.

- States report that the vast majority of beneficiary problems in managed care are resolved informally without filing written grievances. Ombudsman and health benefit counselors have been used successfully to resolve complaints.

Introduction

The Henry J. Kaiser Family Foundation and the federal Health Care Financing Administration have launched a state symposia series entitled, "Transitioning to Managed Care." The National Academy for State Health Policy has been funded to organize the symposia. The purpose of the symposia is to convene small groups of state Medicaid officials to explore in detail critical issues they confront in building Medicaid managed care programs. Each symposium will focus on a single topic of interest.

This paper is based upon the first symposia, held October 23, 1996 in Washington, D.C. and attended by 40 individuals representing states, HCFA, consumer advocates, other managed care experts, and Foundation and Academy staff. (See Appendix A for a complete list of participants.) The topic of the symposia was "Medicaid Managed Care Consumer Protections".

Considerable work is being conducted by states, the federal government and others to establish measures of quality and systems of quality assurance in managed care, such as the Quality Assurance Reform Initiative and Medicaid HEDIS, but less formalized attention has been devoted to other critical avenues for consumer protection. The symposium and this paper focus on the practical strategies states can create to assure beneficiaries have the information they need to select and use a health plan and the capacity to easily express complaints and grievances. This paper is not intended to provide a detailed explanation of state approaches but rather to synthesize key findings from a selected group of experienced states and present the lessons they have gleaned from their work in developing approaches to protect consumers of Medicaid managed care.

1. Enrollment and Disenrollment

The process of enrolling beneficiaries into Medicaid managed care plans is a critical component of providing access to quality health care services. State participants have built their systems with the expectation that beneficiaries who know what they need and prefer and who voluntarily select a plan that meets those needs are more likely to be satisfied with the plan. Such beneficiaries will also more likely use services, particularly preventive services, as they are needed. Beneficiaries need a process that fully informs them about the availability of plans and their networks, the implications of managed care and the procedures for effectively accessing services when needed.

Enrollment in a health plan is a discrete function which entails much more than determining eligibility. During the enrollment process, beneficiaries learn about managed care, how to select a plan that is best for them and how to use that plan appropriately. Enrollment requires beneficiaries to make sometimes complicated decisions to select the plan that will best serve their health care needs and those of their families. The enrollment function therefore requires considerable consumer education and information and oversight about how plans present and market information about their services.

The scope and definition of enrollment systems varies significantly by state, reflecting their unique environments and resources. Generally, all states agree that enrollment should include client outreach, education, and assistance or counseling to make a choice among competing plans. Some states link enrollment with disenrollment and hold the same staff who are responsible for enrollment accountable for tracking disenrollments. But additional roles have also been contemplated for enrollment staff. Some argue that the enrollment process should include health assessments and health education, while others feel these are more appropriately plan responsibilities. Some states have combined enrollment with responsibility for complaint systems and assisting beneficiaries to resolve difficulties. Others argue that enrollment must be a neutral and independent function and that such neutrality would be compromised if the enrollment staff or broker also handled beneficiary complaints.

Managed care organizations are particularly concerned about clarifying the function of the enrollment staff and seek to assure that information presented about them is neutral and fair. States have taken a variety of approaches in crafting their enrollment systems. This has been done by state employees, third party enrollment brokers, or by the managed care plans themselves.

Some states have allowed health plans to conduct their own marketing and enrollment. However, abuses and a concern that beneficiaries were not aware of

the full range of plan options available to them led many of those states to use state employees or independent organizations to conduct these functions. One informal study[1] found that 24 states utilize a third party broker and 10 states use public employees to enroll beneficiaries in Medicaid managed care programs.

Enrollment can be performed through several arrangements: state income maintenance workers who are responsible for determining welfare and Medicaid eligibility (Missouri), Medicaid employees (Rhode Island, Utah, Washington), interagency agreements with another state agency (in Oregon, the Senior and Disabled Services Division enrolls aged and disabled beneficiaries), county employees (Minnesota) or staff of an independent private contractor (Delaware, Indiana, New Jersey, Ohio). New York may use a private contractor in some counties and local Department of Social Service or Health Department staff in other counties.

a. **Using state staff**

The ten states that engage public employees to conduct enrollment functions vary in how those staff are used. States have used re-trained eligibility workers, Medicaid staff, local department of health staff, welfare eligibility workers and county employees

Rhode Island is one example of a state that uses a dedicated state work force for managed care enrollment. Eligibility workers who were being laid off due to cutbacks in the state's general assistance program were re-trained and reassigned. Effective training, clear definitions of responsibilities and accountability to the Office of Managed Care contributed to the success of the process. The workers were paired with AFDC beneficiaries participating in the state's "Pathways" program, a transitional employment and training initiative. This produced an additional benefit as many of the AFDC beneficiaries were ultimately hired by Managed Care Organizations (MCOs) as customer service representatives.

Utah uses state Medicaid workers as health program representatives to conduct education, counseling, enrollment, disenrollment and to handle complaint functions. The representatives are located in welfare eligibility offices. During the Medicaid eligibility process, beneficiaries view a video, receive information on each Managed Care Organization (MCO) and have online access to review the list of providers in each MCO. In rural areas, the volume of managed care enrollment was too low to use full time, dedicated

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1 Mary Kenesson. Based on interviews and communications from state Medicaid staff.

staff. In response, the Division of Health Care Financing contracted with local Health Departments to explain the fee for service, primary care case management and limited MCO options to beneficiaries. In addition to managed care enrollment, the Health Departments were contracted to work with physicians to promote the program and improve immunization rates and WIC participation. This arrangement was viewed as successful as evidenced by a 65% rate of voluntary managed care enrollment in some rural areas.

Washington uses primarily state staff to conduct enrollment for AFDC beneficiaries but also trains case managers in the Aging and Adult Services Administration system, SSI case workers in the Department of Social and Health Services as well as staff in local Health Departments and allied social service agencies to enroll SSI beneficiaries. Enrollment may be completed by using a toll free number, fax and even e-mail. Plans are required to notify all new enrollees of their enrollment and request that they select a primary care physician within 45 days.

If state or county employees are used as brokers, states recommended that training, supervision and management be conducted by the Medicaid agency rather than by cash assistance eligibility workers. Eligibility workers have had competing responsibilities - AFDC, food stamps, WIC - which makes it more difficult for those workers to master the complexities of Medicaid and the choices of managed care plans. As states implement the new requirements of the Temporary Assistance to Needy Families (TANF) program, which de-couples automatic eligibility for Medicaid from welfare eligibility, additional attention will need to be given to how best to assure effective enrollment in Medicaid managed care.

b. Using enrollment brokers

A growing number of states have elected to use independent brokers as a way to initiate and administer enrollment systems more quickly and independently than state budgets and civil service requirements may allow. Outside organizations can adjust staffing levels more quickly to accommodate changes in the volume of Medicaid enrollment which can be varied and unpredictable. This is particularly true in states implementing 1115 waiver demonstration programs that expand eligibility to populations that are not otherwise eligible for Medicaid. Oregon, for example, found that new applicants did not want to apply for a "welfare" program so the state contracted with a broker and located enrollment counselors outside of local welfare offices. Enrollment increased faster than anticipated and the contractor was able to respond with added staffing more quickly than a state agency. This development has created new responsibilities for the state

agency, brokers and plans. The state agency retains responsibility for managing and overseeing the entire managed care program; however, portions of the state responsibilities, such as counseling and assisting beneficiaries with plan selection, are delegated to other organizations. Plans continue to be responsible for educating members about plan procedures and utilization of services. Plans also provide information to the enrollment and counseling entity about covered services, location of services and provider networks which is compiled for use in the counseling and enrollment process.

Medicaid managers in some states hold regular meetings with enrollment brokers as a means of discussing the process, identifying problems and developing improvements. Enrollment brokers and plan representatives also hold meetings or forums to inform the public about the program. Some states indicated that plans generally object to brokers. Plans prefer to do their own enrollment and they have voiced concerns about the way information about their plans may be presented. Plans also prefer to capitalize on the first opportunity to educate enrollees about their plan. Over time, Rhode Island found that plans developed a more collaborative than competitive relationship among themselves. Early in the process, each plan wanted to present its position on a specific topic during open forums. Over time, the plans divided the topics and one plan representative would cover the issue for all participating plans.

Enrollment broker companies that hire staff with experience in state government and coordinators/counselors from local communities were considered to be more effective models. Hiring of local personnel increased the number of bi-lingual and multi-cultural counselors which improved the effectiveness of the counseling function.

c. Broker contracting, monitoring and reimbursement

States exert oversight over independent brokers through the expectations identified and monitored through contracts with them and by the methods used to reimburse them. Broker contracts should specify what functions will be performed, by whom and what criteria will be used to monitor contract performance. Broker agencies are now paid either through a "flat rate" or a rate based on each beneficiary enrolled. Maximum contract amounts or fixed budgets may be more costly than enrollment-based contracts when volume is low and brokers are not serving many individuals. Ohio switched from a maximum contract amount in which the broker invoiced for expenses to an enrollment-based method of reimbursement.

At this time there appears to be no single preferred approach to reimbursement of enrollment brokers. Enrollment-based payment methodologies are more sensitive to volume changes. However, enrollment-based reimbursement may create incentives to expedite enrollments without adequately educating and informing beneficiaries before they make selections. If the broker organization is also responsible for complaints and disenrollments, it may have an incentive to ignore or delay responding to complaints or requests to change plans. States raised concerns about the efficacy of using disenrollment and auto assignment rates as a measure of broker performance since it is particularly difficult to define what is an appropriate rate. For example, if brokers are responsible for disenrollment and reimbursement is tied to a threshold for disenrollment, the broker has an incentive to discourage members from leaving a plan with which the beneficiary is unhappy. To counter these incentives, state agencies in Delaware and Oregon (for aged and disabled beneficiaries) process all disenrollment requests directly.

Delaware and Indiana set maximum contract amounts for broker agencies. Plans and consumers have complained that the broker is not educating members adequately which the broker attributed to limited funding. Delaware plans to conduct a satisfaction survey in 1997 and the results will be used to re-evaluate the rate of reimbursement during contract renewal.

Meeting participants cautioned that states must avoid repeating abuses found among some plans that conducted marketing directly and therefore needed to examine carefully the incentives created by reimbursement methodologies for brokers. Each state noted the importance of clear performance measures such as the number of calls answered within a specified number of rings, lost calls, waiting time, information packages mailed and received, member satisfaction with the enrollment process, enrollment within a specified number of days, accuracy of information, follow up calls to members and the level of disenrollment.

Several participants indicated that rates of auto assignment and disenrollment are used to measure the effectiveness of the enrollment process. Low auto assignment rates and limited disenrollment have been deemed to indicate that the education and choice counseling process is working, beneficiaries are making appropriate plan selections and are satisfied with the plans selected. In some states, staff monitor voluntary enrollment and disenrollment and meet with brokers whose rates vary from those anticipated in order to determine the reason for the higher rates.

Missouri imposes sanctions if the auto assignment rate exceeds a threshold. Although Ohio does not include penalties for auto assignments or

voluntary disenrollment, state staff work closely with each broker agency and plan to conduct follow up surveys to measure member satisfaction.

New York will withhold a portion of the payments which are only paid to the broker if thresholds for auto assignment rates, waiting time, phone times, lost call rates and other measures are met. New Jersey also monitors completed call rates, waiting times and abandoned calls using data obtained directly from a tracking system rather than reports from the broker. Enrollments must be completed within three days with a 98% accuracy rate.

However, comparing disenrollment among states is likewise difficult because states define disenrollment differently. Some states define disenrollment as leaving a plan for any reason (changing to another plan, loss of eligibility and disenrollment "for cause" (plan initiated). Other states do not count a beneficiary who changes plans as a disenrollment. Disenrollment in states with mandatory enrollment cannot be compared with states with voluntary managed care programs since beneficiaries in many mandatory states may change plans only once or twice a year, depending on the length of the lock-in period.

d. Approaches to enrollment - the role of auto assignment

The aim of enrollment systems is to assure beneficiaries make informed decisions and select a plan most appropriate for them. But even the most sophisticated enrollment systems find that some beneficiaries are hard to reach or do not make a choice and are, therefore, automatically enrolled in a plan (auto-assignment).

States described using computerized methods for auto assignment. New Jersey auto assigns randomly by county to plans that have capacity to accept new enrollees. Rhode Island and New Jersey provided beneficiaries as many as three opportunities to select a plan before being assigned - by mail, during a re-certification visit and through a follow up phone call. Enrollment counselors had a list of the primary care providers and the plan with which they were affiliated to help beneficiaries select a plan that allowed them to retain their existing provider. Because of the effectiveness of the counseling process, 93% of the Rhode Island beneficiaries voluntarily selected a plan during the initial enrollment phase. Indiana auto assigns beneficiaries who lose and re-gain Medicaid eligibility based on the physician and plan they had used before losing eligibility.

States were cautioned to assure that auto-assignment does not result in children being assigned to adult medicine practitioners and to assign families as a unit whenever possible while still allowing for individual enrollment in

a plan when necessary. Several states allow temporary exceptions to assignment or selection of a plan such as surgery that is scheduled with a non-plan physician, women in their third trimester, chronic disabling conditions with stable provider relationships, terminal conditions and language barriers.

Beneficiaries in Delaware are pre-assigned to one of four plans. Beneficiaries receive a letter notifying them of the assigned plan and allow them to select another plan if they choose to do so. A follow up phone call is made and beneficiaries have 30 days to make a new selection. Very few beneficiaries change from the assigned plan because 90% of all providers in Delaware belong to all four plans.

Washington provides two opportunities for clients to select a plan before being assigned. First, all newly eligible clients receive an enrollment packet by mail which they must submit within 45 days to avoid assignment. They are advised that they may choose a plan by mail or fax after reviewing the enrollment packet's provider listings and plan summaries or they may call a benefit specialist who will help them select a plan by phone. Benefit specialists have access to a provider database, which lists provider type and plan, that is updated monthly. The enrollment packet information is updated annually.

Clients who do not respond within 45 days receive a "reminder" letter telling them who they will be assigned to if they do not voluntarily select another plan within three weeks. Plans are alerted to the clients who received assignment letters so that the clients can be contacted to verify plan selection and to make PCP choice prior to the enrollment start date. This is particularly important for pregnant women to assure continuity of prenatal care.

When creating the reminder letter, clients are first screened. Native Americans in certain areas are assigned to tribal clinics; newborns are assigned to the mother's plan; family members are assigned to currently or formerly enrolled family members' plan; and clients with breaks in eligibility are assigned back to their former plan. The clients who are reconnected with plans constitute about 50% of clients needing reminder letters each month. About 50% of clients who have not chosen a plan within 45 days of eligibility determination are assigned to plans who have available capacity in their area, using an algorithm reflecting the quality, access and price scoring in the RFP process. The process favors plans that scored highest in the bidding process.

Lessons

- States agree that enrollment should include client outreach, education, and assistance or counseling to make a choice among competing plans.

- Combining enrollment, complaints resolution and disenrollment in one broker contract may compromise the neutrality of the enrollment process (eg., a counselor who sees complaints may be likely to discourage enrollment into that plan).

- If disenrollments are handled by a broker, disenrollments "for cause" should still be approved by the state Medicaid agency especially if the broker has an incentive to delay or discourage such actions. Plans should not approve disenrollments.

- Striking a balance between steering beneficiaries to an appropriate plan versus inappropriate steering can be difficult. State and independent health benefits counselors should be monitored to detect enrollment patterns that may indicate bias.

- States use a range of options for performing the enrollment functions including public employees and private contractors. Contracted enrollment brokers give states more flexibility to adjust to fluctuations in the workload as private sector organizations can add or reduce staffing more quickly than state agencies.

- States which select an independent broker need a contract that clearly specifies responsibilities of the broker, clarifies the relationships among the state, the enrollment broker and plans and creates appropriate incentives for the enrollment broker. The contract with a broker should be consistent with the contract with plans.

- States need to develop oversight and monitoring activities for broker arrangements, identifying the risks and methods for holding brokers accountable. Criteria for broker performance include: call waiting times, lost call rates, mailing volume, auto assignment rates, voluntary disenrollment or plan switching rates, number of complete enrollment applications received by the state agency, client satisfaction surveys, ethnic, legislative and cultural staffing in relation to consumers being served, analysis of enrollment trends to monitor counselor bias and complaints from MCOs and other organizations.

- State agencies should approve the qualifications and training of key health benefits management staff.

- The method of reimbursing broker contractors creates incentives and disincentives which require criteria and performance measures that effectively monitor broker activity to avoid creating incentives to impeded disenrollment.

- Based on the variations observed among states concerning the definition of disenrollment, it would be helpful to have a clear national definition of the term.

- Enrollment systems that are experienced, community-based, culturally competent and which have on-site, not just telephone, access can more effectively reach Medicaid beneficiaries than larger, centralized systems.

2. Consumer involvement

Whether enrollment and disenrollment are handled by the state or by an independent entity, states described the importance of involving consumer advocacy and community groups in developing an enrollment and disenrollment strategy. An open process is helpful in developing marketing and plan comparison materials, and identifying what information is needed to make informed decisions so that the system is user friendly. For example, stakeholder groups were formed in each county in Washington to help design and monitor the counseling and enrollment process. Participants included client advocates (such as legal services), providers (primary care physicians, hospitals, clinics), allied social service agencies, health departments, head start and clients. The stakeholder groups reviewed policies, helped identify local conditions that would effect enrollment and met on a regular basis to share information about the program. As a result, community groups became very knowledgeable about the program which helped with marketing and explaining the program, and their involvement has continued as the program has been implemented.

Advocates can fulfill valuable roles in reviewing materials presented to prospective members and helping plans build on the existing network of community organizations. Consumers can review materials and anticipate problems in the process of counseling, choice and enrollment. For example, one state translated a brochure into multiple languages and included graphics in an attempt to conduct effective outreach. A community coordinator noted that the brochure for Middle Eastern beneficiaries had drawings of women with bare arms, legs and heads which might have offended some beneficiaries. Because the problem was identified early in the process, the brochure could be changed before it was distributed. Further, when systems are designed with consumer groups, states find that the consumers become invested in the success of the program. A

consumer group in one state helped review contracts, prepared a plan comparison chart and worked with the state to conduct brief exit interviews with beneficiaries to determine what they understood about the process.

Consumers can also play a role in monitoring the counseling and enrollment process. Consumers can become "secret shoppers" to observe counselors and report on the extent to which beneficiaries are given non-biased information. Many states conduct regular meetings among state managers, health benefits managers and consumers and report that these forums provide processes for early identification and resolution of problems.

States have also held focus group meetings with consumers to review the experience and perceptions of beneficiaries. However, attracting Medicaid members to focus group meetings to discuss managed care is often difficult. Rhode Island holds four focus group meetings a year for beneficiaries. The sessions are held in a local hotel rather than a community agency, which officials suggest contributes to the success of the meetings. Attendees are provided a meal, day care, transportation and $20 for participating. The focus groups produced valuable insights and the incentives have boosted attendance.

Washington officials held 20 client focus groups in 1996 which targeted beneficiaries that were likely to experience difficulties accessing services such as limited English speaking populations, people with disabilities and homeless beneficiaries.

Lessons

- Ongoing involvement of consumers in the enrollment process can assure that the system is "user friendly" and materials are easily understood.
- Advocates may be used to interview enrollees to help assess the effectiveness of the counseling process.
- Consumer advocates and representatives can be used to review and comment on policies and procedures.
- Regular meetings among state managers, brokers and advocacy groups/consumers can identify conflicts and issues before they become significant problems.
- Community agency representatives may act as "secret shoppers" to monitor marketing and enrollment activities.
- Consumer focus groups are difficult to organize yet they provide valuable feedback to state policy makers and managers. Holding the meetings at a

local restaurant and providing transportation and day care services increased attendance in one state.

3. Outreach and education

A number of activities are necessary to acquaint beneficiaries with managed care. State agencies, brokers, plans, advocates, providers, and beneficiaries all have roles in outreach, marketing and education to assure an effective managed care system.

Beyond identifying and contacting beneficiaries to educate them about the program and the choices they must make to participate, procedures are required to help beneficiaries, once enrolled, schedule needed appointments and ensure that they access services. Educational activities undertaken through the counseling and enrollment process, and by health plans once a member is enrolled, help beneficiaries learn how to use the managed care system.

Outreach covers a range of activities from reaching newly eligible beneficiaries, connecting with enrolled members, to working with hard-to-reach or serve members. It is important for states to determine the outreach functions to be performed by state agencies, enrollment brokers and plans. Rhode Island determined that reaching new eligibles was a state responsibility and the Office of Managed Care utilized billboards, press releases and community organizations to advertise the program. Rhode Island has used encounter data to review how members are accessing services. Activities include a study of all births by census track, examining birth records and conducting home interviews.

Community organizations can also have a role in outreach and states can help build these relationships between MCOs and community-based organizations. Rhode Island organized a day long outreach seminar for managed care organization staff and community groups. Community representatives made presentations on how to reach low-income members and each community organization had a booth where MCO staff could learn about their services. As a result, some MCOs developed contracts with community organizations for home visiting and services.

Washington has developed a variety of outreach efforts. Medicaid officials conduct seminars to train community representatives and to provide information about recent program or policy changes. MCOs contract with community service organizations to perform outreach activities and the RFP review process gives higher scores to MCOs that have such contracts. The state agency holds quarterly meetings with MCOs and includes MCO representatives in presentations at community forums, health benefits and fairs to discuss their services.

Enrolling members has been easier than educating beneficiaries about managed care. Education efforts in several states have shifted emphasis from choosing a physician or plan to educating about how to access care and how to use an MCO. Participants noted the importance of face-to-face meetings rather than phone or mail to begin the education process. States have found that they cannot rely on physicians to educate members. It is difficult, and some might contend inappropriate, to use physicians to convey information since physicians often can spend too little time with members during office visits. However, some plans have their staffs located in the physician's waiting room to work with members. Several MCOs in Ohio use a mentoring process where enrollees themselves contact other members and encourage pre-natal visits and immunizations for children. Minnesota and Ohio identified the importance of working with community social services organizations and courts to educate staff of these organizations about how beneficiaries use MCOs. For example, members were sometimes referred to non-plan providers for court ordered treatment. If properly informed about managed care, ancillary agencies such as courts may alter the way they make referrals and use alternate providers. Social service agencies can help contact and inform hard to reach beneficiaries about the importance of accessing health care services.

Meeting member needs beyond health care has helped MCOs to encourage preventive care. For example, one MCO in Arizona surveyed members to identify their needs. Members identified help finding employment, enrolling children in Head Start and getting clothing for children as primary concerns. The health plan them devised a program whereby coons or vouchers for these things were offered to members once they completed a preventive care visit. These coupons could be exchanged for clothing collected by business organizations and other services during a swap meet, or Wellness Fair. The Fair featured booths an sessions on health, wellness and safety issues (bicycle safety lessons, "Dentalsaurus" dental hygiene shows) as well as booth to redeem vouchers for donated clothing and other needed services. Representatives from community agencies also attended to provide information to members about other needs and interests that they had identified. These fairs were sponsored by the health plans and were open to the entire community.

Medicaid beneficiaries without telephones have been difficult to reach and are more likely to be "auto assigned" to a plan. However, although the reasons are not clear, states reported that health plans seem to have had greater success than state agencies reaching members without phones.

Finally, New Jersey and other states stressed the importance of the initial health assessment by the plan in helping beneficiaries access appropriate services.

Lessons

- States need to clearly define roles and expectations of state agencies, plans, and brokers in marketing, outreach, and education, and assure consistency and accuracy of the message provided to beneficiaries.

- Press conferences, billboards, brochures placed in locations frequently visited by beneficiaries and individual mailings have been used in successful outreach efforts.

- Good education initiatives maximize opportunities to have face-to-face encounters to increase knowledge of managed care when beneficiaries interact with the system. These opportunities can be created by locating health plan staff in physician waiting rooms, using emergency room staff, hotlines and the complaint process.

- State agencies (Social Services, Courts, Education) and community- based organizations should be well informed about the managed care system in order to avoid conflicts.

- Encounter data can be used to identify members who are not accessing services and trigger follow up from health plans and maximize consistent and accurate information to enrollees.

- Efforts that bring MCOs and community organizations together build solid relationships and bridges to Medicaid members, especially hard to reach members.

- Group orientation sessions have not been effective due primarily to low attendance.

- Health plan staff need to understand the availability of community services and resources such as Head Start and WIC in order to access supplemental services.

- Medicaid beneficiaries can be effective in conducting outreach activities with their peers.

- Successful outreach requires an on-going effort and not just one-time activities.

- Health plans should complete an initial health assessment for all new members.

4. Complaints and grievances

a. Formal and informal approaches

States have implemented a variety of systems for resolving disputes in addition to the standard Medicaid fair hearing process. These systems vary among states and can include informal complaint or grievance processes, and/or state formal grievance systems. Federal rules require all Medicaid contracting MCOs to have an internal grievance process. An informal system typically accepts and resolves complaints through phone calls and discussions. The informal process can be implemented by the MCO, a state agency or organization designated by the state Medicaid agency or both. A more formal grievance system is typically triggered by a written complaint filed by the beneficiary or representatives which is reviewed by designated officials and a written response is prepared within specified time frames. The fair hearing process is required by federal law and requires a written complaint, documentation and a hearing before an official whose decisions are binding.[2] Some participants felt a common definition of complaints was needed and that beneficiaries need to understand the difference between a complaint and a grievance. Satisfaction surveys might also include questions about the complaint and grievance procedures.

Complaints provide an early warning to state contract managers and can be used to identify and resolve problems which need attention. Complaints can arise from incorrect interpretations of contract language or language which does not contribute to achieving the goals or behaviors state officials had intended. An effective complaint monitoring process can be used to review and improve state policy, contract language and plan performance.

States reported that most managed care problems arise due to misunderstandings or poor communication and the rate of resolution is reported to be very high without using a formal grievance system. State representatives felt that a complaint resolution process addresses all but a few of the concerns experienced by MCO members and, while a more formal system is necessary, it has been rarely used in most states.

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2 Jane Horvath and Neva Kaye. *Snapshot of Medicaid Managed Care: Ombudsman and Grievance Procedures.* National Academy for State Health Policy. November, 1996.

b. Other approaches to respond to complaints and grievances

In monitoring enrollment brokers and managed care organizations, Medicaid staff in many states review plan complaint logs for trends. The contract language which defines what is reported in this log will determine how useful the process may be.

Some states representatives did caution that it is sometimes difficult to identify situations involving a denial of service or referrals. If the member receives a denial verbally and does not ask for a written notice, a complaint may not be filed and tracking cannot occur.

In a number of states, enrollment staff or brokers are now being asked to respond as well to complaints and grievances. As the workload resulting from initial enrollment diminishes, states may find enrollment staff have available time, making it logical to expand their activities. However, state participants questioned whether the same staff should handle enrollment and complaints. Enrollment brokers are intended to be unbiased yet if they accept complaints they may be influenced to steer beneficiaries to other plans. On the other hand, beneficiaries may want to know how plans compare on the number, type and resolution of complaints. Bias may also enter the process if the broker advises beneficiaries about a plan's capacity and experience serving members with particular conditions. Plans with providers that are more liberal in authorizing particular services or that develop special programs to treat specific conditions may receive a disproportionate share of high cost enrollees. Plans are likely to raise concerns if any activity compromises the independence of the enrollment function.

Assigning responsibility for the complaint and grievance process within an ombudsman program can be used to create a visible and known place for beneficiaries to report complaints and can serve a function in educating members about their rights and responsibilities. Ombudsman services can be structured as a state Medicaid function or delegated or contracted to an external organization. State programs may lack independence and be driven by agency goals rather than client goals. However, a state ombudsman has more leverage and authority since it acts with the authority of the Medicaid agency which contracts with the plans. An internal program also has closer links to data from the MMIS to investigate complaints as well as ties to the policy process to clarify practices or introduce change. An external ombudsman may be more independent and speak up more freely than state agency staff, yet can lack authority or leverage to resolve complaints. Participants agreed that, regardless of the location, the ombudsman needed the authority and access to people who can resolve problems.

Minnesota's statute established an ombudsman program for all health care service delivery issues. Located in the Medicaid agency, the state reports that the ombudsman is viewed as a neutral investigator and educator. Over 98% of the complaints are resolved simply by providing information, most involving complex service coordination or billing issues. Minnesota's counties also play an advocacy role and intervene with plans on behalf of beneficiaries to resolve problems. Both the ombudsman and the counties work to resolve problems and to educate enrollees, providers and plans about the Minnesota program and its requirements.

With active county involvement, the Minnesota ombudsman resolves individual complaints and reviews complaints for trends within a plan. The information is given to contract managers for use in their oversight activities and will also be used in developing performance measures for plans.

Oregon's system was shaped in part by advocates who originally preferred an independent role for investigating and resolving complaints. However, the ombudsman was created as part of the Medicaid agency. The ombudsman gathers information which is forwarded to the state contract managers where resolution generally occurs. State officials indicated that the advocacy community now perceives that the system is working well as an internal function. In Utah grievances and complaints are addressed through the state's health benefits managers but very few have been reported. Over five years, only a few complaints have actually been filed as formal grievances and state officials believe that problems have been resolved informally at the plan level. Health benefits managers in Delaware, which has a contracted system, are also responsible for resolving complaints or assisting with filing a grievance when necessary.

Ohio offers several avenues for enrollees to submit complaints: each HMO's internal grievance process, a toll free number to the Department of Human Services (DHS), and through enrollment information centers. Complaints filed with the state agency are logged and tracked. MCOs must report all complaints filed through their internal process which are checked by DHS staff during quarterly monitoring visits. The DHS logs include enrollee name, date, MCO name, source of complaint (800 number, enrollment information center, direct), description of the complaint and the date and manner of resolution. The MCO logs and reports to DHS include the enrollee name, date, final resolution, date of decision and description of the grievance.

Lessons

- Beneficiaries need to be educated on how to use and access proper complaint and grievance procedures.

- Most problems can be resolved through an informal complaint process in which the beneficiaries can contact either an ombudsman or a health benefits counselor to intervene with the plan.

- States need systems of oversight to assure that beneficiaries can freely air grievances and to assure that information, plan-based systems are fair and effective.

- States have used innovative approaches to reach beneficiaries and assist them in resolving complaints. In Tennessee and Oregon prisoners staff hotlines designed to assist Medicaid beneficiaries. Utah relys on local health benefits managers while Minnesota and other states have developed ombudsman programs.

- Continuing outreach and education is needed in order to ensure that beneficiaries are aware that they have recourse when services are denied.

Conclusion

No single, consistent strategy can yet be defined which articulates the "best" way to inform and protect Medicaid beneficiaries as states transition their programs to managed care. However, states are actively involved in innovative approaches to reach, educate, and enroll beneficiaries, engage them in system design, and build effective systems to hear and resolve complaints and grievances. Throughout these activities, states are consulting with both beneficiaries and plans to involve them in policy development.

Medicaid beneficiaries have unique needs and systems must be able to respond to a variety of social, health and special health needs as well as to a culturally diverse population. States have experimented with a variety of approaches discussed in this paper to address those needs and about 24 states are now negotiating with and contracting for independent enrollment brokers. Whether enrollment is conducted by the state or contracted out, states use a variety of measures to test the effectiveness of systems. Some of those measures, such as disenrollment rates and rates of auto assignment, remain controversial in part because no consensus exists about how these terms are defined and, as a result, how appropriate rates can be determined.

States which are using enrollment brokers also are still grappling with how best to pay them for their services without creating inappropriate incentives to enroll and retain beneficiaries regardless of their preferences.

States appear to have reached consensus, however, about the value of engaging beneficiaries and their advocates in a wide range of system design and oversight activities. States also report that complaints and grievances are best resolved as informally as possible at the plan level, but stress the importance of beneficiary advocacy, such as ombudsman or county or state staff, and oversight of complaint and grievance mechanisms.

States remain active in testing and developing strategies to inform and enroll Medicaid beneficiaries in Medicaid managed care. As states gain more experience, forums such as that sponsored by HCFA and the Henry J. Kaiser Family Foundation provide valuable opportunities for exchange of information and new thinking for further program innovation.

APPENDIX A

National Academy for State Health Policy
Comparison of functions of enrollment brokers

State	Enrollment agent	Functions					Payment
		Education	Enrollment	Disenrollment	Complaints	Other	
Delaware	Broker	•	•		•		Contract amount
Indiana	Broker	•	•	•	•	Some QI activities	Contract amount
Minnesota	Counties	•	•	•	•[2]		Contract amount[3]
Missouri	DFS[1]	•	•	•			Per enrollment
New Jersey	Broker	•	•	•	•[8]		Per enrollment with incentives
New York	TBD[4]	[5]	•	•			Contract amount with performance incentives
Ohio	Broker	•	•	•	•[9]		Enrollment
Oregon	State	[10]	•	•	[10]		NA
Rhode Island	Medicaid	•	•	•	•		NA
Utah	Medicaid	•	•	•	•		NA
Washington	Medicaid[6]	•	•	•	•[7]		NA

1. The FY 98 budget proposes to move the enrollment function from the Division of Family Service to the Medicaid agency.
2. In addition to enrollment staff, counties also have advocates who receive and resolve complaints.
3. Contract amount is based on the number of beneficiaries in the county.
4. Responses to an RFP are being reviewed. A mix of private brokers and local DSS or Health Departments are anticipated.
5. Education may be included depending on the responses to the RFP.
6. Washington also uses Aging and Adult Services Admninistration (aging network) case managers, Department of Health SSI case managers and local Health Department and local allied Social Service Agency staff but most enrollment is done by Medicaid staff.
7. Specialized, dedicated staff handle disenrollment with RN and contract manager support.
8. Handle enrollment, disenrollment and transfer related complaints, not service complaints.
9. The broker receives and routes complaints but does not investigate or resolve them.
10. A mix of Department of Human Resources, Senior and Disabled Services Division and Area Agenices on Aging staff handle enrollment and disenrollment. Education functions were handled by a third party during start up. Inmates in the state's correctional system presently handle phone calls and send out information. Complaints are handled by an ombudsman at the state agency.

APPENDIX B

Kaiser-HCFA State Symposia Series: Symposia I
October 23, 1996
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HCFA: Health Care Financing Administration
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